



Protecting Employers' most valuable asset: **Employees**

JOB ANALYSIS FORM

Claimant 's Name: _____

S.S.# ____ - ____ - ____ Claim # _____

Job Title: _____

Division Name: _____

Address: _____

Telephone (Incl. Area Code): _____

Contact: _____ Title: _____

This Employee is Considered (Check One):

_____ Unskilled _____ Semi-Skilled _____ Skilled

Product or Service: _____

Job Description (Use Back if Necessary): _____

Earning (\$ Per Hour): _____ Hours (Per Week) _____

Education/Experience/Skills Required: _____

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Physical Demands (Per work day)

(N) Never

(M) Minimally 0-5%

(O) Occasionally 6-33%

(F) Frequently 34-66%

(C) Continuously 67-100%

Standing _____

Walking _____

Sitting _____

Carrying _____

Lifting _____

Pushing _____

Climbing _____

Balancing _____

Bending _____

Kneeling _____

Crouching _____

Crawling _____

Reaching _____

Handling/Dexterity _____

Driving/Distance/foot Controls Involved _____

Seeing _____

Speaking _____

Hearing _____

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Environmental Conditions (Describe as Necessary)

<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Comments</u>
Inside			_____
Outside			_____
Heat			_____
Cold			_____
Temperature Change			_____
Wet			_____
Dry			_____
Humid			_____
Dust			_____
Noise			_____
Vibrations			_____
Fumes			_____
Is adequate lighting provided?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is work area heated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
In summer, is work area air conditioned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Furniture provided:			_____

Is there any equipment or machinery used?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, describe or list:			_____

Is the lavatory is reasonably close proximity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Physicians Signature: _____

Date Signed: _____ Date Last Examined: _____

Name/Title/Telephone# of Authorized Representative for Employer (Please print/type)

Signature: _____

Date Job Authorized: _____